PSYCHIATRIC SECURITY REVIEW BOARD
Temporary Leave Application, Pursuant to C.G.S. Section 17a-587

Accompanying this Temporary Leave Application, the hospital shall submit a report to the PSRB that includes, but is not limited to, the information listed below.

a. A summary of the acquittee's current treatment, treatment progress and the clinical rationale supporting this Temporary Leave Application
b. A risk assessment, including risk and protective factors and the risk management plan
c. Temporary Leave Application Community Provider Approval Form(s) (if applicable)

A. ACQUITTEE INFORMATION

Name: **Date of Birth:**

Gender: **PSRB ID No.:**

1. Acquittee Citizenship

Is the acquittee a United States citizen? ☐ Yes ☐ No

Does the acquittee have a passport? ☐ Yes ☐ No

If *yes,* who will hold the passport while on temporary leave?

If acquittee ***is not*** a United States citizen, answer the following questions.

a. Of what country is the acquittee a citizen?

b. What is the acquittee's immigration status? (Attach appropriate documentation)

☐ Lawful Permanent Resident (has a "green card")
☐ Resident alien
☐ In the United States on a visa
Type of visa:
Expiration date:
☐ Undocumented ("illegal") alien
☐ Other (please explain below)

c. Is the acquittee legally able to obtain employment? ☐ Yes ☐ No

If *yes*, please attach verifying documentation.

2. DNA Registry

a. Has the acquittee been asked to provide a DNA sample pursuant to Connecticut General Statutes Section 54-102g? ☐ Yes ☐ No

If *no,* explain.

b. Has a DNA sample been collected? ☐ Yes ☐ No

If *no,* explain.

c. Will the acquittee be required to register as a sex offender, pursuant to Connecticut General Statutes Section 54-250 through 54-261? ☐ Yes ☐ No

3. Court Actions or Orders, Detainers, Restrictions

a. Currently, are there any pending civil or criminal court actions or proceedings? ☐ Yes ☐ No

If *yes,* please describe.

b. Currently, are there any civil or criminal court orders or detainers, FBI or Secret Service detainers or other restrictions or notification requirements in effect? ☐ Yes ☐ No

If *yes,* please describe.

c. Currently, are there any court restraining orders in effect regarding the acquittee? ☐ Yes ☐ No

If *yes,* please describe.

d. Currently, is the acquittee on probation as a result of other criminal convictions? ☐ Yes ☐ No

If *yes,* attach copy of the Conditions of Probation Order.

4. Conservator (attach appropriate documentation)

a. Does the acquittee have a **Conservator of Estate**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:
Fax #:

b. Does the acquittee have a **Conservator of Person**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:
Fax #:

c. Does the acquittee have a **Conservator of Medication**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:
Fax #:

d. Does the acquittee have a **Conservator of Medical Care (or Treatment)**? ☐ Yes ☐ No

Probate Court:
Conservator Name:
Address:
Telephone #:
Fax #:

5. Family and Marital Status

a. What is the acquittee's marital/relationship status? (Check all items that apply)

☐ Single, never married
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Involved in a relationship with a significant other

b. Does the acquittee have children who are under 18 years of age? ☐ Yes ☐ No

If *yes,* please answer the following questions.

(1) Are there any current court orders regarding the acquittee's parental rights, custody, support, visitation, and/or contact with the these children? ☐ Yes ☐ No

If *yes,* please attach a copy of the relevant order(s).

(2) Is the Connecticut Department of Children and Families (DCF) involved? ☐ Yes ☐ No

If *yes,* please provide the following information.

Name of DCF Worker:
Address:
Telephone #:
Fax #:

B. TEMPORARY LEAVE SUPERVISION

Supervision

While on this Temporary Leave, will the acquittee be supervised? ☐ Yes ☐ No

If yes, the Temporary Leave Supervisor is a:

- ☐ Community treatment provider
- ☐ Family member(s)
- ☐ Friend
- ☐ Other person (e.g., AA or NA sponsor). Please describe below.

For supervision provided by a friend, family member(s), or other person, please answer the following questions. ☐ **N/A**

1. Name(s) of Temporary Leave Supervisor(s):
   Relationship(s) to Acquittee:
   Address(es):
   Telephone Number(s):

2. While using this Temporary Leave, how will the acquittee be supervised?

- ☐ Supervised and able to be seen by the Temporary Leave Supervisor(s) **at all times**
- ☐ Supervised and able to be seen by the Temporary Leave Supervisor(s) **at all times** except when using the restroom
- ☐ In his/her own custody, but with Temporary Leave Supervisor (s) in the **immediate or adjacent area**
- ☐ In his/her own custody, but with Temporary Leave Supervisor(s) **available on the premises** for the acquittee to contact
- ☐ Other (please describe below)

3. Has the treatment team met with and evaluated the proposed Temporary Leave Supervisor(s)? ☐ Yes ☐ No

   If *yes*, please answer the following questions.

   (a) Has the treatment team provided the proposed Temporary Leave Supervisor(s) pertinent history and current information about the acquittee's psychiatric disability, substance use, and relevant clinical and risk management issues? ☐ Yes ☐ No

   If *no*, please explain.

   (b) Does the proposed Temporary Leave Supervisor(s) fully understand the responsibilities involved **and** appreciate the necessity for supervision requirements? ☐ Yes ☐ No

   If *no*, please explain.

   (c) Does the proposed Temporary Leave Supervisor(s) listed above have any criminal and/or substance abuse history(ies)? ☐ Yes ☐ No

   If *yes*, please explain.

For supervision provided by a community mental health agency, Department of Mental Retardation or individual treatment provider(s), please answer the following questions. ☐ **N/A**

1. Agency Name:
   Agency Executive Director:
   Name of Temporary Leave Supervisor:
   Address:
   Telephone #:
   Fax #:
   Pager/Cell Phone #:

2. Temporary Leave Supervisor will monitor the Temporary Leave and perform the following services at the indicated frequency.

   Services to be provided (check all that apply): Frequency

   - ☐ Supervision meetings with acquittee
   - ☐ Supervision telephone calls
   - ☐ Visits to acquittee's residence
   - ☐ Individual therapy
   - ☐ Supportive counseling
   - ☐ Group therapy
   - ☐ Reporting to CVH by telephone
   - ☐ Meetings with CVH treatment team
   - ☐ Contacting all other service providers
   - ☐ Verification of attendance at community substance abuse support meetings
   - ☐ Random drug/alcohol screenings
   - ☐ Contact with acquittee's employer
   - ☐ Other services (specify below)

3. While using this Temporary Leave, how will the acquittee be supervised?

- ☐ Supervised and able to be seen by staff **at all times**
- ☐ Supervised and able to be seen by staff **at all times** except when using the restroom
- ☐ In his/her own custody, but with staff in the **immediate or adjacent area**
- ☐ In his/her own custody, but with staff **available on the premises** for the acquittee to contact
- ☐ Other (please describe below)

C. COMMUNITY PROVIDER TRAINING AND INVOLVEMENT

1. Has the proposed Temporary Leave Supervisor completed formal PSRB training? ☐ Yes ☐ No

   If *yes,* date:

2. Have other involved community providers, including relevant supervisory staff, completed formal PSRB training? ☐ Yes ☐ No

   If *yes,* please indicate:

   Staff Name/Agency Date

   If *no,* when will training be completed?

   Staff Name/Agency Date

3. Have the Temporary Leave Supervisor and relevant community providers been orientated by the treatment team regarding their roles and responsibilities to the hospital (and the acquittee) during this Temporary Leave? ☐ Yes ☐ No

4. Have the Temporary Leave Supervisor and relevant community providers been given a current copy of the *PSRB Acquittee Information Packet*? ☐ Yes ☐ No

5. Have the Temporary Leave Supervisor and relevant community providers attended the acquittee's hospital treatment planning meetings and been actively involved in planning this temporary leave? ☐ Yes ☐ No

D. TEMPORARY LEAVE PLAN

Therapeutic purpose

What is the therapeutic purpose of this Temporary Leave? (Check all items that apply)

- ☐ Participate in community-based treatment and/or rehabilitation
- ☐ Learn and practice community living skills
- ☐ Stay overnight/live in the community
- ☐ Enhance and/or maintain relationships with friends, family or significant others
- ☐ Leisure/recreation

☐ Other (please explain below)

PHASE I

1. Frequency

How frequently will the acquittee be able to use this Temporary Leave?

Acquittee will use this Temporary Leave:

up to Hour(s) per day

up to Day(s) per week

up to Time(s) per month

Or, please describe below.

2. Location

Please describe the location(s) where the acquittee will be using this Temporary Leave.

3. Duration

What is the minimum amount of time this Temporary Leave (or phase) is expected to last? (If relevant)

4. Activities

Complete all applicable sections listed below detailing activities in which the acquittee will be participating.

a. Community Providers (list all) ☐ **N/A**

(1) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(2) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(3) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(4) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(5) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(6) Agency:

Executive Director:
Address:
Telephone #:
Fax #:

b. Treatment Activities ☐ **N/A**

Agency	Contact Person	Activity	Frequency

c. Couples/Family Therapy ☐ **N/A**

Agency	Contact Person	Frequency

d. Psychosocial/Educational/Other Community Support Activities ☐ **N/A**

Agency	Contact Person	Activity	Frequency

e. Pre-Employment Vocational Services ☐ **N/A**

Agency	Contact Person	Activity	Frequency

f. Employment ☐ **N/A**

(1) Type of Employment (Check all that apply)
- ☐ Volunteer
- ☐ Sheltered Workshop
- ☐ Competitive

Employer(s) Name(s):
Address(es):
Telephone #:

(2) Based on clinical considerations, how many hours may the acquittee work per week?

(3) Has CVH staff oriented the acquittee's work supervisor(s) and relevant managers? ☐ Yes ☐ No

If *yes,* by whom:

If *no,* when and by whom will this be done?

(4) Will vocational counseling/other vocational services be provided to the acquittee while employed? ☐ Yes ☐ No

If *yes,* please specify:

Agency:
Executive Director:

Contact Person(s):
Address:
Telephone #:
Fax #:

g. Activities with Friends/Family/Others ☐ **N/A**

Activity	Location	Frequency

5. Overnights/Residential Plan

a. Where will the acquittee be staying overnight during this Temporary Leave? (Check all that apply)

☐ No overnights
☐ Acquittee's residence
☐ Family's residence

Name	Relationship

☐ DMHAS or DMR residential program
☐ Acquittee's residence with support services from a DMHAS funded or DMR funded residential program
☐ Other mental health/human services agency residential program
☐ Other (please explain below)

b. Frequency of Overnight Visits

☐ Community transition	up to	Overnight(s) per week
	up to	Time(s) per month
☐ With family/significant other	up to	Overnight(s) per week
	up to	Time(s) per month

Acquittee's address:

Acquittee's telephone number (if available):

c. If proposed housing is a community-based residential program of DMHAS, DMR, or other mental health/human services agency, please complete the following.

Type of residential program:
Type of license from DPH:
Agency:
Executive Director:
Program Name:
Contact Person:
Address:
Telephone #:
Fax #:

Residential Program Staff Coverage/Availability

☐ On-site 24-hours per day, 7 days per week
☐ On-site during work week, plus 24-hour beeper/telephone coverage
☐ Off-site during work week, plus 24-hour beeper/telephone coverage
☐ Off-site beeper/telephone coverage 24 hours per day, 7 days per week
☐ Other (please describe below)

Residential Program Services

☐ Budgeting assistance
☐ Directly observe medication being taken

- ☐ Monitor medications by counts, medication boxes, etc.
- ☐ Individual counseling
- ☐ Group counseling
- ☐ Drug/alcohol counseling
- ☐ Random drug/alcohol screening
- ☐ Vocational rehabilitation program
- ☐ Daily living skills training/assistance
- ☐ Medical assistance
- ☐ House/residents/support group
- ☐ Structured recreation
- ☐ Visit acquittee's residence
- ☐ Congregate meals
- ☐ Other (please describe below)

d. Is there a recommendation for a curfew, sign-in/sign-out log, or other form of residential monitoring? ☐ Yes ☐ No ☐ N/A

If *yes*, please describe.

e. Required staff visits to the acquittee's residence other than by the Temporary Leave Supervisor for the purposes of monitoring and supervision. ☐ N/A

Frequency:
Contact Person:
Agency:
Address:
Telephone #:
Fax #:

6. Monitoring of Medication Compliance ☐ **N/A**

Method of Monitoring:
Frequency:
Agency/Relationship:
Contact Person (If community agency):
Address:
Telephone #:
Fax #:

Method of Monitoring:
Frequency:
Agency/Relationship:
Contact Person (If community agency):
Address:
Telephone #:
Fax #:

7. Drug and Alcohol Screenings ☐ **N/A**

By CVH

Type:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

By other persons or agencies

Type:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

8. Travel and Transportation

a. Who will provide transportation for the acquittee? (Check all that apply)

- ☐ CVH
- ☐ Community agency
  Name(s) of agency:
- ☐ Family/Significant other
  Name(s) of Family/Significant Other:
- ☐ Public transportation in own custody
- ☐ Acquittee's own vehicle (attach a copy of registration and proof of insurance)
- ☐ Other (please describe)

b. Are there limitations for where the acquittee may travel within the State of Connecticut? (Include towns or locations prohibited) ☐ Yes ☐ No

If *yes*, please describe.

c. May the acquittee travel and participate in leisure/recreation activities in his/her own custody? ☐ Yes ☐ No

(1) Describe any time limitations for travel during leisure time in his/her own custody.

(2) Describe any geographic limitations for travel during leisure time in his/her own custody.

d. Recommendations Regarding Motor Vehicles

(1) Is it recommended that an acquittee be permitted to drive a motor vehicle? ☐ Yes ☐ No

If yes, describe the recommended conditions or restrictions and attach a copy of the driver's license.

(2) May the acquittee have passengers? ☐ Yes ☐ No

If yes, describe any recommended conditions or restrictions.

(3) May the acquittee be a passenger in a motor vehicle driven by someone other than a community provider? ☐ Yes ☐ No

If yes, describe any recommended conditions or restrictions.

PHASE II ☐ **N/A**

1. Frequency

How frequently will the acquittee be able to use this Temporary Leave?

Acquittee will use this Temporary Leave:

up to Hour(s) per day
up to Day(s) per week
up to Time(s) per month

Or, please describe below.

2. Location

Please describe the location(s) where the acquittee will be using this Temporary Leave.

3. Duration

What is the minimum amount of time this Temporary Leave (or phase) is expected to last? (If relevant)

4. Activities

Complete all applicable sections listed below detailing activities in which the acquittee will be participating.

a. Community Providers (list all) ☐ **N/A**

(1) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(2) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(3) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(4) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(5) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

(6) Agency:
Executive Director:
Address:
Telephone #:
Fax #:

b. Treatment Activities ☐ **N/A**

Agency	Contact Person	Activity	Frequency

c. Couples/Family Therapy ☐ **N/A**

Agency | Contact Person | Frequency

d. Psychosocial/Educational/Other Community Support Activities ☐ **N/A**

Agency | Contact Person | Activity | Frequency

e. Pre-Employment Vocational Services ☐ **N/A**

Agency | Contact Person | Activity | Frequency

f. Employment ☐ **N/A**

(2) Type of Employment (Check all that apply)
- ☐ Volunteer
- ☐ Sheltered Workshop
- ☐ Competitive

Employer(s) Name(s):
Address(es):
Telephone #:

(2) Based on clinical considerations, how many hours may the acquittee work per week?

(3) Has CVH staff oriented the acquittee's work supervisor(s) and relevant managers? ☐ Yes ☐ No

If *yes*, by whom:

If *no*, when and by whom will this be done?

(4) Will vocational counseling/other vocational services be provided to the acquittee while employed? ☐ Yes ☐ No

If *yes*, please specify:

Agency:
Executive Director:
Contact Person(s):
Address:
Telephone #:
Fax #:

g. Activities with Friends/Family/Others ☐ **N/A**

Activity | Location | Frequency

5. Overnights/Residential Plan

a. Where will the acquittee be staying overnight during this Temporary Leave? (Check all that apply)

- ☐ No overnights
- ☐ Acquittee's residence
- ☐ Family's residence

Name Relationship

- ☐ DMHAS or DMR residential program
- ☐ Acquittee's residence with support services from a DMHAS funded or DMR funded residential program
- ☐ Other mental health/human services agency residential program
- ☐ Other (please explain below)

b. Frequency of Overnight Visits

☐ Community transition	up to	Overnight(s) per week
	up to	Time(s) per month
☐ With family/significant other	up to	Overnight(s) per week
	up to	Time(s) per month

Acquittee's address:
Acquittee's telephone number (if available):

c. If proposed housing is a community-based residential program of DMHAS, DMR, or other mental health/human services agency, please complete the following.

Type of residential program:
Type of license from DPH:
Agency:
Executive Director:
Program Name:
Contact Person:
Address:
Telephone #:
Fax #:

Residential Program Staff Coverage/Availability

- ☐ On-site 24-hours per day, 7 days per week
- ☐ On-site during work week, plus 24-hour beeper/telephone coverage
- ☐ Off-site during work week, plus 24-hour beeper/telephone coverage
- ☐ Off-site beeper/telephone coverage 24 hours per day, 7 days per week
- ☐ Other (please describe below)

Residential Program Services

- ☐ Budgeting assistance
- ☐ Directly observe medication being taken
- ☐ Monitor medications by counts, medication boxes, etc.
- ☐ Individual counseling
- ☐ Group counseling
- ☐ Drug/alcohol counseling
- ☐ Random drug/alcohol screening
- ☐ Vocational rehabilitation program
- ☐ Daily living skills training/assistance
- ☐ Medical assistance
- ☐ House/residents/support group
- ☐ Structured recreation

☐ Visit acquittee's residence
☐ Congregate meals
☐ Other (please describe below)

d. Is there a recommendation for a curfew, sign-in/sign-out log, or other form of residential monitoring? ☐ Yes ☐ No ☐ N/A

If *yes*, please describe:

e. Required staff visits to the acquittee's residence other than by the Temporary Leave Supervisor for the purposes of monitoring and supervision. ☐ N/A

Frequency:
Contact Person:
Agency:
Address:
Telephone #:
Fax #:

6. Monitoring of Medication Compliance ☐ **N/A**

Method of Monitoring:
Frequency:
Agency/Relationship:
Contact Person (If community agency):
Address:
Telephone #:
Fax #:

Method of Monitoring:
Frequency:
Agency/Relationship:
Contact Person (If community agency):
Address:
Telephone #:
Fax #:

7. Drug and Alcohol Screenings ☐ **N/A**

<u>By CVH</u>

Type:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

<u>By other persons or agencies</u>

Type:
Frequency:
Agency:
Contact Person:
Address:
Telephone #:
Fax #:

8. Travel and Transportation

b. Who will provide transportation for the acquittee? (Check all that apply)

☐ CVH
☐ Community agency
Name(s) of agency:
☐ Family/Significant other
Name(s) of Family/Significant Other:
☐ Public transportation in own custody
☐ Acquittee's own vehicle (attach a copy of registration and proof of insurance)

☐ Other (please describe)

b. Are there limitations for where the acquittee may travel within the State of Connecticut? (Include towns or locations prohibited) ☐ Yes ☐ No

If *yes,* please describe.

c. May the acquittee travel and participate in leisure/recreation activities in his/her own custody? ☐ Yes ☐ No

(1) Describe any time limitations for travel during leisure time in his/her own custody.

(2) Describe any geographic limitations for travel during leisure time in his/her own custody.

d. Recommendations Regarding Motor Vehicles

(1) Is it recommended that an acquittee be permitted to drive a motor vehicle? ☐ Yes ☐ No

If yes, describe the recommended conditions or restrictions and attach a copy of the driver's license.

(2) May the acquittee have passengers? ☐ Yes ☐ No

If yes, describe any recommended conditions or restrictions.

(3) May the acquittee be a passenger in a motor vehicle driven by someone other than a community provider? ☐ Yes ☐ No

If yes, describe any recommended conditions or restrictions.

E. GENERAL CONDITIONS

1. Social Contacts

a. List below the name and relationship to the acquittee of each friend, family member, or significant other with whom the acquittee will or may maintain **regular contact** while using this Temporary Leave.

Full Name Relationship

b. Do any of the friends, family members, or significant others listed above have **recent** histories of substance abuse? ☐ Yes ☐ No

If *yes,* please describe.

c. Do any of the friends, family members, or significant others listed above have histories of criminal activities, arrests, and/or convictions? ☐ Yes ☐ No

If *yes,* please describe.

2. Limited or Prohibited Contacts

a. While using this Temporary Leave, may the acquittee have contact with the victim(s) of his/her crime? ☐ Yes ☐ No ☐ N/A

If *yes,* under what circumstances/limitations?

b. While using this Temporary Leave, will the acquittee have contact or visits with his/her own children under 18 years of age? ☐ Yes ☐ No ☐ N/A

If *yes,* what are the recommendations regarding contact or visits?

c. While using this Temporary Leave, will the acquittee have ongoing contact with children under 18 years of age known to the acquittee? ☐ Yes ☐ No ☐ N/A

If *yes,* what are the recommendations regarding contact or visits?

If *yes,* has the parent(s) or legal guardian(s) of the children under 18 years of age given their permission for contact with the acquittee? ☐ Yes ☐ No

If *no,* please explain.

d. While using this Temporary Leave, should there be limitations on contact with other children under 18 years of age? ☐ Yes ☐ No

If *yes,* please explain.

e. While using this Temporary Leave, are there other specific persons with whom contact by the acquittee should be limited or prohibited? ☐ Yes ☐ No

If *yes,* please explain.

3. Computer, Internet and E-Mail Access

a. The acquittee will have access to:

Computer	☐ Yes	☐ No
Internet	☐ Yes	☐ No
E-mail	☐ Yes	☐ No

b. Are there any contraindications/risk management issues for access? ☐ Yes ☐ No

If *yes,* please describe the recommended restrictions.

4. Call-In

Please describe the schedule for the acquittee calling in to the hospital.

5. Assessment

Please describe the frequency of clinical assessments by CVH of the acquittee.

6. Other Conditions

Are there any other recommendations for this Temporary Leave? ☐ Yes ☐ No

If *yes,* please explain.

7. Finances ☐ **N/A**

a. How will the costs of the proposed services and living expenses be covered?

(Check all that apply)	Type (If applicable)	Amount
☐ Savings		
☐ Insurance		
☐ Government entitlements		
☐ Employment		
☐ DMHAS		
☐ DMR		
☐ Family		
☐ Other (specify below)		

b. Please list any housing costs (rent, mortgage, etc.) to be paid by the acquittee.

c. Please list any costs for treatment or support services to be paid by the acquittee.

d. Please describe any fiscal concerns related to this temporary leave and how they will be addressed.

e. Does the acquittee require budget assistance? ☐ Yes ☐ No

If *yes*, who will provide that service?

f. Does the acquittee require third party payeeship? ☐ Yes ☐ No

If *yes*, who will provide that service?
Provider:
Contact Person (if other than provider):
Address:
Telephone #:
Fax #:

Temporary Leave Application Signatures

1. Temporary Leave Application was prepared by:

_____ Date_____

2. Temporary Leave Application was reviewed and approved by:

_____ Date_____
CVH Attending Psychiatrist

_____ Date_____
Consulting Forensic Psychiatrist, DMHAS

_____ Date_____
CVH Superintendent/Designee